EPI-LOG

Communicable Disease and Epidemiology News

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Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.
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Farewell to Our Editor

Sherry Lipsky, P.A.-C, M.P.H., has been the editor of the Epilog since September, 1996, as well as our hard working lead epidemiologist for the food borne illness and enteric disease surveillance system. In order to complete her doctoral degree requirements, Ms. Lipsky decided to reduce her work commitment. She has taken a new, part-time position with the HIV/AIDS program where she will work on expanding Public Health's HIV counseling and testing services to include viral hepatitis. Best wishes to her in her new endeavors.

In April, the editorship of the Epilog will be assumed by Jane Koehler, D.V.M., M.P.H. Jane comes to us from the Communicable Disease Section at the State of Georgia Health Department. In addition to Epilog editor, Jane will be our senior epidemiologist for enteric diseases and our bioterrorism preparedness/response programs.

Influenza Waning

Influenza activity in Washington State, including reports of laboratory confirmed influenza cases, has dropped dramatically since the second week of January, and is now classified as "sporadic" according to CDC criteria. Peak activity for influenza in the 1999-2000 season for Washington State, and the rest of the nation, was the last week of December and the first week of January. In comparison, the peak for the 1998-99 season did not occur until late January through early February. Reports of absenteeism from Washington schools remain very low. While deaths from pneumonia and influenza (P&I) have been higher this year than in previous years, it is likely that CDC's recent changes to the P&I surveillance system could be the explanation. Since implementing the changes, almost all weeks have been above levels normally expected. A/Sydney/05/97(H3N2) remains the predominant strain of influenza isolated this season.

Public Health – Seattle & King County (PHSKC) is interested in establishing enhanced, year-round influenza surveillance. Improved surveillance will provide a more complete picture of influenza epidemiology, current activity and morbidity, and allow for more rapid detection of unusual outbreaks such as the summertime outbreaks among Alaska cruise ship travelers that have occurred in recent years. Better surveillance is also a critical part of an overall pandemic influenza preparedness plan. If you are interested in participating in year-round influenza surveillance, call Laurie Stewart at 206-296-2735.

For information about national influenza surveillance, see: http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm

N. meningiditis from the Nasopharynx

At any given time, 5-10%, and sometimes more, of the population may be asymptomatic, nasopharyngeal carriers of *Neisseria meningitidis*. Although persons in close contact with cases of invasive meningococcal disease are at increased risk of developing invasive disease themselves, contacts of asymptomatic meningococcal carriers are not known to be at increased risk. In addition, recovery of meningococci from the throat does not correlate with the development of invasive disease. Chemoprophylaxis is recommended only for intimate contacts of persons with *invasive* meningococcal disease (i.e., meningitis, septicemia, pneumonia).

Please call Public Health at 206-296-4774 to report cases of invasive meningococcal disease or to clarify chemoprophylaxis recommendations. The 1997 Red Book Report of the Committee on Infectious Diseases, American Academy of Pediatrics, contains current treatment recommendations for persons with meningococcal disease and their contacts; as does the Feb 14, 1997 MMWR (V46, RR-5):(ftp://ftp.cdc.gov/pub/publications/mmwr/RR/RR4605.pdf.)

To monitor the disease in Washington, the Public Health laboratory confirms and serogroups *Neisseria meningitidis* isolates associated with invasive meningococcal disease. Please confirm that your laboratory routinely directs all blood, CSF, and joint aspirate isolates, as well as sputum isolates from persons with meningococcal pneumonia, to the Public Health laboratory to facilitate epidemiologic investigations.

Shower of Shigella

On January 21, PHSKC investigated a cluster of febrile, diarrheal illnesses affecting 6 of 12 persons attending a baby shower on January 15. One attendee was culture-positive for *Shigella sonnei*. A cohort study implicated (p=0.015) a commercially distributed, ready-to-eat, 5-layer bean dip produced by Sec or Felix, Los Angeles County, CA and purchased at a local retail store. Prior to PHSKC's investigation, the retail store (in response to a complaint from one of the baby shower attendees), had determined that Sec or Felix and San Diego County Health officials were investigating 4 foodborne outbreaks possibly due to *Shigella sonnei*! This news prompted our local retail store to remove the bean dip from their shelves the morning of January 21. PHSKC contacted California health officials who confirmed the reports from the retailer. The FDA was notified and that evening the first public warning about the product was issued.

Local surveillance was intensified to find additional cases associated with consumption of bean dip and similar products. A

confirmed outbreak-related case is defined as a laboratory-confirmed *Shigella sonnei* in a person who became ill in January and reported eating the implicated bean dip within 7 days prior to illness onset. Individuals who developed diarrheal illness after eating the dip but lacking laboratory confirmation were classified as suspect cases. By February 14, PHSKC had documented 77 confirmed and 33 suspect cases. Molecular strain typing analysis using pulse field gel electrophoresis (PFGE) and restriction fragment length polymorphism (RFLP) demonstrated that several initial isolates were identical, consistent with a common outbreak strain. The outbreak strain of *S. sonnei* as identified by PFGE was cultured from a leftover sample of the dip consumed by a confirmed case.

Over 200 cases have now been confirmed in California, Idaho, New Mexico, Oregon, and Washington.

Sec⊂or Felix' 5-Layer Party Dip was sold in 16, 20, 41, and 45 oz. containers and distributed under several labels: Sec⊂or Felix' 5-layer Fiesta Dip, Delicioso 5-layer Fiesta Dip, and Trader Joe's 5-layer Fiesta Dip (20 ounce containers). The dip contains black beans, tomato salsa, guacamole, nacho cheese, sour cream and a second cheese sprinkled on top. Some, but not all, varieties of the dip contained preservatives; curiously, ill persons appear to have eaten the preservative-free product. None of Sec⊂or Felix' other products (i.e., salsa, guacamole, burritos, casseroles, hommus) have been implicated in this outbreak. The FDA is still investigating, and no clear mechanism for contamination of the product has yet been identified.

Public Health recommends treatment for acute, febrile, inflammatory (blood and pus in stool) enterocolitis. Antimicrobial treatment of *Shigella* can shorten the duration of systemic symptoms, stop the diarrhea, and shorten the period of shedding the organism in the feces. Therefore, indications for treatment include not only reducing the suffering due to acute dysentery syndrome, but to interrupt transmission of this highly infectious organism to other persons. Antimicrobial drug susceptibility testing of the outbreak strain found resistance to ampicillin/sulbactam and trimethoprim-sulfamethoxasole. In the United States, fluoroquinolones are usually the treatment of choice for empiric treatment of inflammatory diarrhea in adults. Therapy should be adjusted based on antimicrobial susceptibility testing. Appropriate empiric treatment options for shigellosis in children include trimethoprim-sulfamethoxazole, nalidixic acid and extended-spectrum cephalosporins. For susceptible strains, ampicillin is more effective than amoxicillin. Antimotility agents are not recommended and are contraindicated in children.

Persons suspected or known to have shigellosis should be counseled on how to reduce the potential for transmitting the infection to others. Scrupulous attention to thorough handwashing with soap and running water after going to the bathroom, changing diapers, and before preparing food should be emphasized. Cases *and* ill contacts of cases who are foodhanders, patient care workers, or adults or children who work at or attend child daycare settings should avoid these activities until symptoms subside. For these individuals, additional stool samples should be collected to confirm eradication of carriage (2 successively negative stool samples). These should be collected at least 24 hours apart, and 48 hours or more after completion of antibiotic therapy.

Vaccine Course

Mark your calendars for CDC's live four-part satellite course, **Epidemiology and Prevention of Vaccine-Preventable Diseases**, scheduled for 9:00am-12:30pm March 23, 30, April 6 and 13, 2000. Health care providers who give immunizations and/or set policy for their clinics are encouraged to attend. Look for registration details in the next Epi-Log.

Report: **(area code 206)**
AIDS 296-4645
Communicable Disease 296-4774
STDs..... 731-3954
Tuberculosis 731-4579
24-hr Report Line..... 296-4782
After hours 682-7321
Hotlines:
CD Hotline 296-4949
HIV/STD Hotline 205-STDS
http://www.metrokc.gov/health/

REPORTED CASES OF SELECTED DISEASES
SEATTLE-KING COUNTY 2000

	CASES REPORTED IN JANUARY		CASES REPORTED THROUGH JANUARY	
	2000	1999	2000	1999
VACCINE-PREVENTABLE DISEASES				
Mumps	3	0	3	0
Measles	0	0	0	0
Pertussis	14	17	14	17
Rubella	0	2	0	2
SEXUALLY TRANSMITTED DISEASES				
Syphilis	5	6	5	6
Gonorrhea	95	95	95	95
Chlamydial infections	380	311	380	311
Herpes, genital	112	66	112	66
Pelvic Inflammatory Disease	26	22	26	22
Syphilis, late	0	2	0	2
ENTERIC DISEASES				
Giardiasis	20	16	20	16
Salmonellosis	22	17	22	17
Shigellosis	87	4	87	4
Campylobacteriosis	27	17	27	17
E.coli O157:H7	0	2	0	2
HEPATITIS				
Hepatitis A	9	8	9	8
Hepatitis B	4	2	3	2
Hepatitis C/non-A, non-B	0	1	0	1
AIDS	3	12	3	12
TUBERCULOSIS	8	12	8	12
MENINGITIS/INVASIVE DISEASE				
Haemophilus influenzae	0	0	0	0
Meningococcal disease	3	3	3	3